Missouri Department of
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June 26, 2009

The Honorable Jay Nixon
Governor of the State of Missouri
State Capitol Building, Room 216
Jefferson City, Missouri 65101

Dear Governor Nixon:

In Executive Order 07-12 state agencies administering health care programs were charged with developing a plan to address transparency in the delivery and administration of health care. I am happy to forward the enclosed third report dated June 2009, which shares the department's achievements and future plans to incorporate increasing levels of transparency into the MO HealthNet, MO HealthNet for Kids, and Missouri Rx programs.

If you have any questions, please do not hesitate to contact me.

Respectfully,

Ronald J. Levy
Director

Enclosure

Health Care Transparency

in Quality, Price, Interoperability in Health Systems and Incentives to Reward Outcomes

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June 2009

Introduction

On March 2, 2007, Governor's Executive Order 07-12 was issued. This executive order charged state agencies administering health care programs to develop a plan to address transparency in the delivery and administration of health care. This is the third report detailing how the Department of Social Services (DSS) is promoting transparency for the MO HealthNet, MO HealthNet for Kids, and Missouri Rx Plan.

This DSS plan centers on current initiatives and implementation of Senate Bill (SB) 577 (2007), which enacts the Missouri Health Improvement Act of 2007. SB 577 is the culmination of the executive and legislative branches' work to change how publicly financed health care is delivered to Missourians.

The DSS plan focuses on these four areas from the executive order:

- *Support interoperable health information systems and products so long as the maintenance or exchange of health information includes provisions to protect patient privacy as required by law;*
- *Support the development and implementation of objective quality standards for services supplied by health care providers in that program, ultimately making provider performance on these standards available to consumers of the program's services;*
- *Support making information available regarding the prices for procedures or services under the program; and*
- *Make every effort to deliver high quality and cost-effective health care that may include consumer-directed health care plans and reimbursement methods that reward providers for results.*

This report is organized by these four areas.

What is health systems interoperability?

There is no one health care system; health care is delivered through an assortment of disconnected providers with varying levels of technological sophistication. The basic concept of interoperability is easily sharing data. Standards are set so one system can talk to another and they can exchange data accurately, efficiently and securely. By connecting providers and payers, we gain a data supply to dependably measure cost and quality. Dollars saved by minimizing redundancies can be redirected to improving care.

Health Systems Interoperability

- **MO HealthNet's Electronic Health Records in CyberAccess℠** – More than 13,000 physicians and other health care providers use this web-based portal to access electronic health records for MO HealthNet patients. Treating providers can view a patient's medical history including diagnoses, procedures and prescribed drugs. Physicians can electronically submit prescriptions and request pre-certification for imaging procedures and durable medical equipment. CyberAccess℠ improves efficiency of health care delivery by using a rules-based engine to determine if a requested drug or procedure meets the appropriate criteria. All of this is done in a secure environment and the entire system is Health Insurance Portability and Accountability Act (HIPAA) compliant. The tool now includes lab and clinical trait data imported from provider medical records, as well as increased functionality to allow physicians to input notes. MHD will soon be phasing in additional services such as optical and psychology, ensuring appropriate utilization and efficient use of funds.

  Support interoperable health information systems and products so long as the maintenance or exchange of health information includes provisions to protect patient privacy as required by law

- **Medicaid Management Information System (MMIS)** – The MO HealthNet Division (MHD) is updating the current MMIS. The State awarded the MMIS fiscal agent contract to Infocrossing HealthCare Systems on September 7, 2007. The metadata management and HIPAA enhancements will be implemented by November 2009. All other enhancements are scheduled to be completed by October 2010. Many enhancements will be available through a modernized system that will support information sharing among health care partners:

  - Enterprise Services Business Interfaces – These interfaces will simplify and standardize data exchanges between key business partners by providing the compatibility to integrate computer systems running on different platforms regardless of technology or location.

  - Metadata Management – This will promote data sharing between business partners by providing easy to understand data definitions that will enhance the accurate transfer of information between systems.

  - Electronic Health Records – This initiative will draw on participant health records from other insurance companies and providers to supplement the health information we have from MO HealthNet claims. This enhancement will harness more information so the accuracy of clinical edits and care management can be improved.

- Real Time Transaction Processing – Claims adjudication information will be available to providers on a real time basis. Providers can review billing outcomes, determine when payments will be made, and access online primary payment information and online eligibility status.

- HIPAA Enhancements – The new MMIS ensures compliance with nationally mandated standards designed to address security and privacy of health data.

- **Managed Care Organizations (MCOs)** – MCOs, through a contracted relationship with the state, currently provide health care services for 400,752 people enrolled in the MO HealthNet Managed Care Program. The MCOs have a sophisticated claims processing and management information system that interfaces with the state's MMIS. This provides valuable encounter data on managed care enrollees. The state, in conjunction with its contracted actuarial firm and external quality review organization, conducts encounter data validation reviews of the MCOs on an annual basis to improve the comprehensiveness and accuracy of encounter data for use as the primary data source for capitation rate development. Encounter data was used by the state's contracted actuarial firm in the development of the capitation rates for the rebid of the Managed Care contract effective October 1, 2009. These reviews also serve as a basis for implementing and improving best practices by the MCOs. Additionally, the state uses encounter data for reporting of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well child visits (MCO capitation rates were developed based on MCO performance on receipt of well child visits) and supplemental delivery payments to MCOs when a delivery occurs. The state holds regular monthly conference calls with the MCOs for purposes of addressing encounter data problems. The state focused on improvement of inpatient and pharmacy data because the state's actuary determined, based on a review of MCO financial data, that these two sources of encounter data had the highest rate of validity. The Centers for Medicare and Medicaid Services (CMS) recognized the state's efforts to improve the validity of MCO encounter data as a noteworthy practice during the onsite review conducted during the week of March 9, 2009.

- **Non-Emergency Medical Transportation (NEMT)** – NEMT is provided under a contractual relationship and, like the MCOs, the contractor is providing encounter data in a readable format that interfaces with the MMIS. The encounter data is tracked on a monthly basis to assure consistency. The MHD is working towards using encounter data for setting NEMT capitation rates in the future.

- **Electronic Medical Record (EMR) Interoperability** – DSS is exploring opportunities for electronic medical record interoperability to bridge the CyberAccess℠ tool with existing provider-based electronic medical records. In 2007, DSS contracted with BJC Healthcare to bring this concept to the metropolitan St. Louis region. As part of this project, physicians employed by BJC or BJC affiliates will share a common relational database of patient drug and clinical workflow information – all within HIPAA guidelines. Physicians will also have the ability to exchange relevant patient information with external labs and participating hospitals.

  In June 2009, BJC reported that over 200 physicians were using the EMR system, with access to more than 532,000 patient records. The pilot project will end on June 30, 2009 and MHD and BJC intend to continue collaboration to pursue an ultimate goal of full interoperability.

- **Medicaid Transformation Grant - Development of a Web-Based Tool for Home and Community Based Services** – A Medicaid Transformation Grant was awarded to the MO HealthNet Division by the Centers for Medicare and Medicaid

Services (CMS). This grant provides funding to develop an electronic assessment and services allocation tool for home and community based services. This tool is being developed through a cooperative effort with the Department of Health and Senior Services. The Division sought provider input and development is underway with deployment of the initial phase expected in September 2009.

- **A Federally Qualified Health Center Health Information Technology Project** – A Statewide Safety Net Gap Analysis Survey was completed September 2007 with plans to develop and implement electronic health/medical records in each community health center. The requirements for a data warehouse that will provide a centralized location to examine benchmarks, best practices, and increase access to information from a normalized reporting platform have been developed.

  In State Fiscal Year (SFY) 2009, this data warehouse will be fully implemented. It will enable the Missouri Primary Care Association to report aggregated data across all the community health centers in the state. The implementation of the electronic health/medical records will be completed by June 2009.

- **An Electronic Medical Records Pilot for One or More Greene County Skilled Nursing Facilities** – A contract was established with Christian Health Care of Springfield and as of May 2009, 135 residents of one facility were included in their EHR software for both charting and administering medications.

- **A Pilot for Telehealth for Rural Health Clinic Records** – MHD is working with the Missouri Telehealth Network (MTN) at the University of Missouri-Columbia. The program is currently in place and operational, allowing improved access to provider specialties in 28 different clinic sites.

- **Northwest Missouri Regional Electronic Medical Records project** – The General Assembly appropriated $500,000 for SFY 2009 to fund a regionally integrated electronic medical records system linking rural physicians and hospitals in Northwest Missouri. The project will provide a system which integrates health care records within a regional database and utilizes technology that can easily be shared with other health providers, and may be replicated beyond its immediate population. The MO HealthNet Division is in process of establishing a contract through the Missouri Primary Care Association to oversee the project.

- **Health Care Technology Fund** – SB 577 established the Health Care Technology Fund in statute, promoting technological advances to improve patient care, decrease administrative burdens, increase access to timely services and increase patient and health care provider satisfaction. Examples include:

  - Electronic medical records – A contractor is assisting with developing a strategic plan and meetings have been taking place with other state agencies to gain input.

  - Personal and community health records – This is currently under development.

  - E-prescribing – This is currently in place and prescribing providers are beginning to use the tool, with approximately 10 physicians able to e-prescribe. There are 829 pharmacies set up in Cyber who are e-prescribe ready. In addition, there are approximately 80 e-fax prescriptions generated monthly.

  - Tele-medicine – State regulation 13 CSR 70-3.190 established coverage for this 2-way interactive video technology to improve access to needed health services. Coverage began with Psychotherapy effective August 2008 and other

program areas will follow

- Tele-monitoring – This is operational serving approximately 200 participants meeting established criteria in SFY 2009.

- Electronic access for participants and providers to obtain service authorization. Provider access for specific procedures and equipment is currently available and continues to expand over time. The participant web portal is under development and is expected to be operational during the third quarter of 2009.

Why is measuring health care provider performance important?

We want to spend our health care dollars where we will get the best care. Quality of care is of interest to everyone, but measuring it is complex. There is a void of publicly accessible, accurate information on cost and quality, so we are continuing our efforts to make information easier to access and easier to understand.

Quality of Provider Performance

- **Healthcare Effectiveness Data and Information Set (HEDIS)** – HEDIS is a tool used by more than 90% of America's health plans to measure care and service performance. HEDIS makes it possible to compare the performance of health plans on an apples-to-apples basis. Health plans use HEDIS to see where improvement is needed. Annually, DSS requires MCOs to submit independently audited HEDIS performance rates as specified by the National Committee for Quality Assurance (NCQA). The MCO's 2007 HEDIS data demonstrated improvement in annual dental visits ages 2-3 years; asthma-combined rate; and follow-up after hospitalization for mental illness within thirty days of discharge.

- **External Quality Review** – CMS requires an annual, independent, external evaluation of the MO HealthNet Managed Care program. An external quality review is an analysis of aggregate information on quality, timeliness and access to health care services furnished by MCOs and their contractors for MO HealthNet managed care recipients**.**

Support the development and implementation of objective quality standards for services supplied by health care providers in that program, ultimately making provider performance on these standards available to consumers of the program's services

- The 2007 MO HealthNet Managed Care Program External Quality Review Report of Findings was issued in May 2009. Overall, the External Quality Review Organization (EQRO) found continued improvement by the MO HealthNet managed care health plans through validation of health plan performance improvement projects, performance measures, encounter data and compliance with managed care regulations.

- **Children's Health Insurance Program (CHIP) Annual Report** – Effective September 1, 2007, Missouri's Children's Health Insurance Program (CHIP) was moved from an 1115 Waiver to a Children's Health Insurance Program (CHIP) state plan.

  The CHIP Annual Report for the review period of September 1, 2006, through September 30, 2007, had the following conclusions:

  - The CHIP population represents approximately 1% of the entire state population. Without CHIP approximately 59,000 additional children would most likely be uninsured, raising the state's percentage of uninsured children to 14.5% and lowering Missouri's rank for uninsured children to 48th in the nation;

  - CHIP is having a positive effect on medical facilities and emergency rooms (ERs) (e.g., they have fewer avoidable admissions and there are fewer children using the ER when a visit to a physician is more appropriate); and,

  - Given the inconclusive nature of research done in the area of crowd out, no conclusion could be drawn in this area. It is important to note that the Missouri General Assembly's action to extend premium and affordability requirements to a greater portion of Missouri's CHIP population has provided mechanisms to address crowd out.

- **1115 Demonstration Waiver, Women's Health Services** – On October 15, 2007, CMS approved Missouri's Section 1115 demonstration waiver, Women's Health Services Program, effective October 1, 2007. Under this waiver, Missouri provides approved family planning services to uninsured (defined as not having creditable coverage) postpartum women ages 18 to 55 who are losing their MO HealthNet eligibility 60 days after the birth of their child. Additional funding was received for SFY 2009 to expand coverage to women with net family income at or below 185% of the federal poverty level. It is estimated that an additional 83,000 women will receive coverage. An annual evaluation will be conducted by an external agency.

- **Home and Community Based Quality Strategy** – Missouri operates seven Home and Community Based Services (HCBS) waivers which allow individuals to remain in their communities and avoid institutionalization:

  - Aged and Disabled Waiver – Homemaker/chore, respite, and home delivered meals to individuals aged 63 or over;

  - AIDS Waiver – Expanded personal care services, private duty nursing, attendant care and supplies for individuals diagnosed by a physician as having AIDS or an HIV-related illness;

  - Independent Living Waiver – Expanded personal care services, environmental accessibility adaptations, specialized medical equipment and supplies and case management for individuals age 18 to 64 who have a cognitive and/or physical disability;

  - Mentally Retarded and Developmentally Disabled Waiver (MR/DD) – Residential and day habilitation, individualized supported living, behavioral/physical/occupational/speech therapy, respite, personal assistant, community specialist, counseling and crisis intervention, communication skills instruction, supported employment, transportation, home modification and adaptive equipment services to individuals who have mental retardation and/or a developmental disability;

  - Missouri Children with Developmental Disabilities Waiver (MOCDD) – Day habilitation, behavioral therapy, respite, personal assistant services, community specialist services, crisis intervention, transportation, environmental accessibility adaptations and specialized medical equipment and supplies to individuals age birth to 18 who have a developmental disability and whose families have chosen to have the child remain at home;

- Community Support Waiver – Day habilitation, individualized supported living, behavioral/ physical/occupational/speech therapy, respite, personal assistant, community specialist, counseling and crisis intervention, communication skills instruction, supported employment, transportation, home modification and adaptive equipment services to individuals who have mental retardation and/or a developmental disability and receive substantial unpaid support from family members; and,

- Physical Disabilities Waiver – Attendant care services, private duty nursing and specialized medical equipment/supplies to individuals who have serious and complex medical needs age 21 or older and are no longer eligible for services under the Healthy Children and Youth program.

The MO HealthNet Division maintains a Quality Management Strategy (QMS), which demonstrates to the federal government that DSS retains administrative authority of the HCBS waiver programs, and has systems in place to measure and improve its performance in meeting the waiver assurances. These systems assure participant access, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes and satisfaction and system performances.

- **MO HealthNet Managed Care Annual Report** – Each year evaluations of the MCOs in the MO HealthNet Managed Care program are performed. The evaluation contains information concerning the effectiveness and impact of the MCOs' MO HealthNet quality assessment and improvement strategy. The evaluation also reports on compliance with state, federal and MO HealthNet contractual requirements.

  The SFY 2007 MO HealthNet Managed Care Annual Evaluation was presented at the MO HealthNet Managed Care Quality Assessment and Improvement (QA&I) Advisory Group and All Plan meetings in April 2008. Evaluation of network adequacy; travel distance; consumer assessment of health care providers and systems (CAHPS) survey data; HEDIS indicators; provider surveys; performance improvement projects; fraud and abuse; credentialing and recredentialing; subcontractor oversight; and federal rule compliance revealed a continued commitment of the MCOs to provide quality health care to their participants.

- **Hospital Quality Initiative** – This initiative uses a variety of tools to help stimulate and support improvements in the quality of care delivered by hospitals. The intent is to improve quality of care by distributing objective, easy to understand hospital performance data. This will encourage consumers and their physicians to discuss getting the best hospital care, create incentives for hospitals to improve care and support public accountability.

  CMS is working in conjunction with the Hospital Quality Alliance (HQA), a public-private collaboration on hospital measurement and reporting. Among the collaborators are the American Hospital Association, the Federation of American Hospitals and the Association of American Medical Colleges. The collaboration is supported by the Agency for Healthcare Research Quality (AHRQ), CMS, the National Quality Forum, Joint Commission on Accreditation of Healthcare Organizations, American Medical Association, Consumer-Purchaser Disclosure Project, AFL-CIO, AARP and the US Chamber of Commerce. Through this initiative, a robust, prioritized and standardized set of hospital quality measures has been refined for use in public reporting. The Missouri Hospital Association is leading this effort in Missouri.

  From 2003 through today, the national average of the scores has steadily improved with public reporting. A report on hospital charges and collections is at www.focusonhospitals.com.

For SFY 2009, hospitals will be collecting 30 measures including heart attack, pneumonia, and heart failure for the surgical care improvement project (SCIP). CMS publicly displays this data on its Hospital Compare web site, http://www.hospitalcompare.hhs.gov.

- **Quality and the Chronic Care Improvement Program (CCIP)** – In addition to providing care management for chronically ill MO HealthNet patients, one of the key goals of the CCIP is to support health care professionals who are providing high-quality care to their patients. The CCIP health coaches and care coordinators work directly with patients and their physicians to provide support and reinforcement of patient education. Using Care Connection, an internet-based plan of care, all participants – patients, providers, and health coaches – are able to work together more effectively using a collaborative health record, which facilitates communication and information sharing.

  As of March 2009, approximately 140,000 participants, and many of their physicians, throughout the state were participating in CCIP. The Quality Improvement Council (QI), which is part of CCIP, has established a set of quality standards and benchmarks for treating patients with chronic diseases. These standards are used to measure clinical outcomes for the program.

- **Health and Wellness Outcome Survey** – SB 577 provides for the department to commission an independent survey to assess health and wellness outcomes of participants. Components include:

  - Disease-specific outcome measures;
  - Provider network demographics;
  - Provider availability for participants compared to the statewide population; and,
  - Provider and participant program satisfaction.

  The University of Missouri - Center for Health Policy collaborated with the Saint Louis University School of Public Health and the Saint Louis University Center for Outcomes Research to conduct MO HealthNet participant and provider satisfaction surveys. The studies assessed satisfaction with multiple aspects of care delivery and the program itself, as experienced and perceived by both participant and physician stakeholders. Participants responding to the survey were typically between the ages of 25 and 75 who rated their health "fair" or "good." They were generally satisfied with the health care they received; rating care received in the preceding six months an 8 or better on a 10-point scale. The majority of the participants surveyed reported they had one person they thought of as their personal physician or nurse.

  396 physicians were interviewed or surveyed for the provider satisfaction survey. More than half of the physicians surveyed have cared for MO HealthNet participants for 16 years or more, and most worked in practices with only one physician. The majority of respondents rated MO HealthNet "good," "very good" or "excellent" at meeting their needs. Physicians who responded to the survey indicated they would be open to caring for additional MO HealthNet participants. Providers surveyed noted concerns about the variety of specialists available to their patients, and reported dissatisfaction with the reimbursement rate for the services they provided.

  In summary, these analyses indicate that the MO HealthNet program has made meaningful progress toward eliminating historical health disparities in all regions of Missouri. Furthermore, it appears that there have been notable improvements in health outcomes in the

Southeast region of the State and for blacks with chronic disease throughout the state. Enhancing knowledge and awareness with data such as these will foster ongoing improvement in access to and quality of healthcare in Missouri and will increase participant and provider satisfaction with the MO HealthNet program.

Why is sharing health care pricing important?

Freely sharing pricing information is necessary to control costs. We need reliable information so both consumers and government can make valid price comparisons and get the most from their health care dollar.

Sharing Health Care Pricing

- **MO HealthNet Fee Schedules** – MO HealthNet Division on-line fee schedules are updated quarterly and are available at http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm. These schedules identify covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit.

- **Children's Health Insurance Program (CHIP) Premium Schedule** – Individuals in families with income above 150% of the federal poverty level share costs through monthly premiums. Families pay no more than 5% of their annual income for premiums in a year. The premium amounts change effective July 1 of each year. The premium amounts are calculated according to state law (the state budget and MO Revised Statute Section 208.640). Monthly invoices are sent to those individuals owing a premium. Individuals who have questions about premiums should call the Premium Collections Unit at 1-877-888-2811. The premium schedule is posted on the web site, http://www.dss.mo.gov/mhd/providers/pdf/puzzledterm.pdf.

  Support making information available regarding the prices for procedures or services under the program

- **MO HealthNet Managed Care Rates** – Capitation payments are the only payments made to MCOs for contracted services. The MCO capitation rates are public information, which can be obtained from the state of Missouri, Office of Administration, Division of Purchasing and Materials Management. MHD will be posting the rates on its website in the near future.

- **Non-Emergency Medical Transportation (NEMT) Rates** - The NEMT provider capitation payment is the only payment made for contracted services. NEMT capitation rates are public information and can be obtained from the state of Missouri, Office of Administration, Division of Purchasing and Materials Management. MHD will be posting the rates on its website in the near future.

- **Pricing for Procedures and Services - Missouri Rx Price Compare (MoRx Price Compare) –** In January 2007, MoRx Price Compare (http://www.morxcompare.mo.gov/) was launched. The MoRx Price Compare tool was created to give consumers access to medication prices for the most commonly used prescription drugs. MoRx Price Compare uses information captured through the MO HealthNet claims process to create a user-friendly, web-based tool that allows consumers to comparison shop using retail prescription prices. The Web site tool allows Missourians to obtain the best local price for prescriptions by comparison shopping among pharmacies to get the best local price for prescriptions. County, city, zip code and area comparisons can be made. MoRx Price Compare lists prescription medication prices based on the usual and customary price reported by local pharmacies. An uninsured, cash-paying customer would normally pay this retail price without any discounts. Since its launch in 2007, over 50,000 search sessions have been initiated.

- **Medicare and Dental Rates** – SB 577 requires the department to report each January 1 on the status of reimbursement rates compared to 100% of Medicare rates and average reimbursement for dental services by third party payers. On June 30, 2008, the department presented a four-year plan to the General Assembly to achieve parity with Medicare and third party dental rates. A copy of the report is available on the Division's website at http://www.dss.mo.gov/mhd/oversight/resources.htm.

- **Nursing Home and Hospital MO HealthNet Rates** – MO HealthNet reimburses participating nursing facilities on a per diem basis for actual days billed. In May 2009, MO HealthNet began posting the Nursing Facility Rate List on its web site. The rate list includes information on participating nursing facilities including the facility name, MO HealthNet reimbursement rate, city, county, and the number of licensed and certified beds. The rate list is in a user-friendly format (Excel) that can be downloaded to allow users to review and analyze the data to suit their needs. The rate list is updated on a monthly basis and is available at http://www.dss.mo.gov/mhd/providers/pages/nfrates.htm

  MO HealthNet participating hospitals receive payment for hospital services as follows:
  - Inpatient Hospital Stays – MO HealthNet reimburses hospitals on a per diem basis for actual days billed. Additionally, MO HealthNet makes add-on payments to compensate hospitals for costs not reimbursed through the per diem.
  - Outpatient Services – MO HealthNet reimburses hospitals for outpatient services based on a percentage of billed charges.
  - Uninsured – MO HealthNet reimburses hospitals serving a high or disproportionate share of Medicaid or low-income participants for the cost of services provided to the uninsured (i.e., disproportionate share (DSH) payments).

  MO HealthNet is developing a hospital rate list that includes the hospital inpatient per diem rates and the outpatient percentage that will be posted on the web site. The hospital rate list should be available in SFY 2010.

Why is rewarding quality important?

We have a capitalistic society. For every MO HealthNet service there is a maximum fee, but historically we have made no payment distinction between good and bad care. To safeguard our health care we need to balance keeping quality providers in the system with cost effectiveness. To encourage quality, we need to reward providers who practice good medicine and consistently meet established standards of care.

Cost-Effectiveness, Consumer Involvement and Provider Rewards

- **MO HealthNet Managed Care Early Periodic Screening, Diagnosis and Treatment (EPSDT) Adjustments** – In accordance with CMS guidelines, DSS requires 80% of eligible MO HealthNet Managed Care members to have Healthy Children and Youth (HCY)/EPSDT well child visits. DSS measures the MCOs' performance using these well child visits and prorates the monthly capitation payment based on their effectiveness.

  During SFY 2006, 163,450 children (75.9% of eligible children) in the MO HealthNet Managed Care Program received an HCY/EPSDT screening. During SFY 2007, 165,241 children (72.3% of eligible children) in the MO HealthNet Managed Care Program received an HCY/EPSDT screening. During SFY 2008, 169,896 children (67.9% of eligible children) in the MO HealthNet Managed Care Program received an HCY/EPSDT screening.

  Make every effort to deliver high-quality and cost-effective health care that may include consumer-directed health care plans and reimbursement methods that reward providers for results

- **MO Health and Wellness Program** – This is a coordinated health care model that began as the Chronic Care Improvement Program (CCIP) in November 2006. It is a voluntary choice for sufferers of long-term chronic diseases, including diabetes, asthma, chronic obstructive pulmonary disease, gastroesophageal reflux disease, sickle cell disease and cardiovascular disease. The Health and Wellness Program maximizes health information technology by allowing treating providers to access a patient's electronic Plan of Care through a tool called Care Connection, as well as the entire medical history through the widely utilized web-based tool, CyberAcess℠. The latter allows access to electronic prescribing, diagnosis data, ability to receive alerts, selection of appropriate medications, and drug and medical prior authorizations. These tools allow collaborative communication among providers about patient care – reinforcing the provider's treatment and improving the participant's quality of care.

  As of March 2009, approximately 140,000 participants were enrolled in CCIP, along with many of their physicians.

- **High Quality and Cost-Effective Health Care (Direct Care Pro™) –** Direct CarePro™ is a highly innovative Medication Therapy Management (MTM) tool. This application utilizes the pharmacist-patient relationship, focusing on quality of care, wellness initiatives and cost containment. This web-based system assists pharmacists and other appropriate healthcare providers to maintain standards of care for participant's multiple chronic diseases and co-morbidities by utilizing nationally recognized, evidence-based treatment standards. Direct CarePro™ delivers actionable clinical information at the point-of-

service, empowering pharmacists

- **Drug Utilization Review/Prior Authorization (SmartPA™)** – SmartPA™ uses a highly sophisticated clinical rules engine that uses algorithmic criteria derived from best practices and evidence-based medical information to allow transparent approval of service and product requests. It streamlines the prior authorization process for all stakeholders – physicians, allied health professionals and participants, as it adjudicates prior authorizations in real time. All providers who participate in MO HealthNet's fee-for-service program are subject to drug utilization review and prior authorization requirements. Smart MedPA™ technology was implemented in July 2006 utilizing the same clinical rules engine used for SmartPA™. Smart MedPA™ processes precertifications for imaging and prior authorizations for Durable Medical Equipment.

- **Fraud and Abuse** – The department uses Thomson Reuters Advantage Suite®, a comprehensive Fraud and Abuse Detection System (FADS), to identify patterns of inappropriate billing and potential fraud, waste or abuse of the MO HealthNet program. The tools available within the FADS include algorithms that are adapted for use with the MO HealthNet claims database. FADS is used for efficient case development by using its detailed or drill down reports, which identify specific provider and/or participant information to isolate specific claims data to review. The system allows the users to eliminate most false positive results and to concentrate on productive cases that were overpaid. FADS is used daily by the Program Integrity Unit (PIU) staff to run queries and perform research to identify claims. Cash recoveries and cost avoidance total $21.7 million for SFY 2007, $25.3 million for SFY 2008 and $28.5 million for SFY 2009 (through May 2009).

  Long-Term Care Insurance Partnership – Under these partnerships programs, individuals purchase long-term care insurance plans. When long-term care is needed, typically later in life, individuals will use the benefits afforded by the insurance plan. This will allow them to retain a certain amount of assets (assets equal to the amount of long-term care benefits paid on behalf of the individual through a long-term care partnership plan) and still qualify for MO HealthNet long-term care benefits, provided all eligibility requirements are met including resources. This type of program provides an incentive for consumers to be directly involved with health care decisions while protecting individual assets and reducing reliance on publicly funded programs. The Department of Insurance, Financial Institutions & Professional Registration issued regulation and policies which can be purchased after August 1, 2008. Information about these partnership plans can be found on the web at http://www.ownyourfuture.mo.gov/.

- **Health Improvement Plans** – SB 577 provides for the establishment of a high quality and cost effective health care through three types of plans – risk bearing coordinated care (managed care), administrative service organization (non-risk bearing) and coordinated fee for service. Plans are to adhere to the principles of transparency, personal responsibility, prevention and wellness, performance based assessments, achievement of improved health care outcomes and cost effective delivery through technology and coordination of care. Throughout SB 577, references are made to *participants.* This is an important shift from the previous mindset of a *recipient*. Participants will have opportunities to increase their health literacy and become active partners with their health care home in improving and maintaining their health. The goal of a health care home is to assist participants and their support system in accessing primary care services, coordinating referrals and obtaining specialty care.

- **Pay for Performance (P4P)** – The department, in conjunction with the Professional Services Payment Committee, will be developing guidelines to implement pay for performance that will reward providers for quality care. The Center for Health Care Strategies (CHCS) selected MO HealthNet to participate in the Pay for Performance Purchasing Institute. Institute participants receive technical assistance from CHCS and other collaborators in areas such as developing incentive structure, choosing measures and engaging providers.

  Through CCIP, a Quality Improvement Council is working with providers from around the state to develop measures and standards for a pay for performance program. This work may serve as a foundation for the Professional Services Payment Committee to expand P4P for the broader population. The initial CCIP P4P payment, issued to providers in the second quarter of 2008, was developed based on provider's individual results for several standard, peer-reviewed and best-practice clinical outcomes for each of the participant's conditions managed through CCIP. These best practices include use of inhaled corticosteroids for asthmatics, regular acquisition of glycosylated hemoglobin values and screening ophthalmology examinations for diabetics, use of beta blockers and ACE inhibitors for participants with congestive heart failure, measurement of lipid profiles for participants with coronary artery disease, and annual influenza immunizations. Subsequent P4P payments have not been funded.

- **Direct Inform** –The MO HealthNet Division has developed a participant web portal allowing participants to access their medical claim payment information as well as a wide array of links to pertinent health-oriented websites. Direct Inform™ allows participants to self-report many treatments they may seek outside of the MO HealthNet benefit such as over-the-counter and homeopathic treatments. The Direct Inform™ website is a powerful, user-friendly tool that delivers actionable patient specific clinical and economic information regarding personal health and wellness. The tool complies with all applicable HIPAA privacy and security requirements.

- **Deficit Reduction Act of 2005 (DRA)** – MO HealthNet continues to be the payer of last resort. When another payer is liable for the personal injury, disability or disease of a MO HealthNet participant, benefits are assigned to the Department of Social Services, who pursues collection. The participant is required to aid in this pursuit**.** Provisions in Section 6035 of the DRA Act are now incorporated into RSMo 208.215 and 208.217:

  - Within 60 days of receipt, a MO HealthNet participant who receives a third party benefit for a covered illness or injury is required to pay up to the total MO HealthNet benefits provided or place the full amount in a trust account pending final judicial or administrative determination.

  - Settlements cannot be reached in actions in which the MO HealthNet Division may have an interest without first giving the division notice.

  - Upon request by the MO HealthNet Division, all third party payers must provide the division with information contained in a 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under HIPAA.

  - The Department of Social Services is not required to seek reimbursement from a liable third party when the recovery will be less than the cost of recovery.

- Third party administrators, administrative services organization and pharmacy benefit managers doing business in Missouri or administering or processing claims or benefits for residents are subject to MO HealthNet third party liability data match and must comply with HIPAA.

- Third party liability data may be requested at a minimum of twice per year.

- Unless waived by the MO HealthNet Division, a participant's probate estate cannot be closed until the personal representative of the estate obtains a release from the MO HealthNet Division evidencing payment of all MO HealthNet benefits, premiums, or other such costs due to the state under law with the court.

The MO HealthNet Division met with ten Missouri health insurance carriers to discuss topics including eligibility information exchange, data matching and claims payment. The fiscal agent for the MO HealthNet Division developed a Trading Partner Agreement to facilitate the data exchange.

MO HealthNet Responsibility Report – On November 27, 2006, Governor's Executive Order 06-45 was signed, directing the Missouri Department of Social Services (DSS) to prepare a Medicaid beneficiary employer report and submit the report to the Governor on a quarterly basis to be known as the Missouri Health Care Responsibility Report.

In the 2007 legislative session, the Missouri General Assembly enacted Senate Bill 577, which transformed the Missouri Medicaid program into MO HealthNet. Section 208.230 of SB 577 is known as the "Public Assistance Beneficiary Employer Disclosure Act." It directs the Department of Social Services to prepare a MO HealthNet beneficiary employer report. The requirements of Section 208.230 and Executive Order 06-45 are virtually identical.

Starting with the first calendar quarter of 2008, 120 days after each quarter, Department of Social Services prepares a report listing each employer in the state with 50 or more workers who are MO HealthNet participants, have a spouse who is a MO HealthNet participant or who are a custodial parent of a MO HealthNet participant. The public version of the report is available on the MO HealthNet Division Website at http://www.dss.mo.gov/mhd/general/pages/hcrr.htm.

Conclusion

DSS' successful implementation of the principles contained in the executive order to achieve transparency requires engaging all health care partners. Policy and contractual agreements will continue to embody these principles and to be continually scrutinized to ensure they incorporate the best in transparency practices. Standardized transparency language is being added to contracts as they are initiated or rebid.